DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF10127 (01/03) (Formerly DWS 13039)

STATE OF WISCONSIN
WI. Stats. s. 49.472

MEDICAID PURCHASE PLAN (MAPP)
WORK REQUIREMENT EXEMPTION

Instructions: To be completed by an Economic Support (ES) worker. A copy should be sent to client and one placed in case file. Original should be sent to:

Medicaid Purchase Plan
c/o Center for Delivery Systems Development
Attn: Work Exemption Monitor
1 South Pinckney Street, Room 340
Madison, WI 53701

Client Name (First, MI, Last)	Social Security Number	Filing Date

Worker Number	CARES Case Number	PIN

A Medicaid Purchase Plan (MAPP) participant may request to be exempted from the work requirement for up to six calendar months. This would allow an individual who has been participating in MAPP for the last six months, who can not continue to work or participate in a Health and Employment Counseling Program, to continue his or her eligibility in MAPP. In order to qualify for the work requirement exemption the participant must be experiencing a health-related hardship.

According to HFS 103.03(1)(g) of the Wisconsin Administrative Code, a health-related hardship includes those situations in which the participant's health deteriorates to a point where s/he is unable to work or participate in the Health and Employment Counseling program. In order to qualify, the participant must:

- Expect to return to work or his/her Health and Employment Counseling program within the next six calendar months.
- Have participated in MAPP for the last six calendar months;
- Currently be eligible for MAPP and has paid all MAPP premiums owed; and
- Not have been exempted for more than 12 months in the last 36 months.

I, (client name) _____request an exemption of the MAPP work requirement beginning (date - mm/dd/yy)_____ due to a health-related hardship. I expect this hardship to last for (number of months) _____months. I understand that I must provide a doctor's statement, to my ES worker within 10 days of date on the CARES Verification Check List I receive, as verification that I cannot work or participate in a Health and Employment Counseling program due to a health-related hardship. I understand that I may still be required to pay a premium based upon my income.

_____
(Signature - Client)

Name (ES Worker) (First and Last)		Date
☐ Approved ☐ Not Approved	Begin Date	End Date

Reason for Non-Approval (HFS 103.03(1)(g))

Reset Page